Administration and Implementation of Child Maternity and Healthcare Services in Nigeria: An Overview of Bokilga

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Abstract: **- Child maternal healthcare is one of the major goals of the present administration in Cross River State and Nigeria at large. No country achieves meaningful development without tackling child maternal death, since it is a major concern of all countries especially developing nations. The central argument of this research paper is on the factors militating against the smooth administration of child maternal healthcare and the high death of children, these ranges from poverty, low level of education, inaccessibility of healthcare services, unbooked emergencies, and high patronage of Traditional Birth Attendance (TBA) by natives, hypertensive disorder of pregnancy, obstructed labour, anemia, hemorrhage and infection. The issue of maternal health should be accorded priority through reducing maternal mortality rate by government and other relevant stakeholders.**

Functionalist approach to healthcare system is used as a theoretical framework to explain how a society can be understood in its totality as an entity unto itself, emphasizing how the system can work in a different and better way to deliver health outcomes when government spend about 70-80% of the country resources available for healthcare at the point of need of them, this will make a huge difference, especially in the issue of maternal mortality rate.

The researcher purposive selected fifty (50) health workers and one hundred (100) beneficiaries of the scheme to make the sample size 150. The papers concluded by noting that most maternal death are avoidable, if women have access to antenatal care during pregnancy, has trained (skilled care) at labor and both the baby and the mother are under standard medical care during and after delivery, and continue till the first two weeks after delivery.

Keywords: **child maternal care, maternal healthcare, mortality rate, administration of healthcare**

I. INTRODUCTION

Sustainable development and zero tolerant for maternal health is a major target of every country that intends to achieve human development. Maternal child care is a key indicator of a society's level of development and the performance of the health care delivery system. Majority of the causes of these deaths are preventable. The World Bank Statistics indicated that at least 144 women die each day from pregnancy-related complications in Nigeria, placing the country among one of the worst in the world for women to deliver babies.

Child Maternal care is one of the major challenges to health systems in the world and sub-Saharan Africa, in particular. In order to encourage the international community to address this challenge, maternal mortality reduction was included as one of the Sustainable Development Goals (SDGs). The target of SDGs 3aims is to reduce under-five mortality to at least as low as 25 per 1,000 live birth, it also aim to reduce maternal mortality to less than deaths per 100,000 live birth.Maternal mortality is the single most important health issue facing obstetricians, gynecologists and Nigerians. Most Nigerians, especially women who are poor, are very vulnerable to illness, disability and even death owing to lack of access to comprehensive health services, particularly reproductive health services. These women need quality reproductive health services, such as medical care, planned family, safe pregnancy, delivery care and treatment and prevention of sexually transmitted infections like HIV/AIDS. With accessibility to comprehensive reproductive health services, women are less likely to die in pregnancy, more likely to have healthier children and better able to balance their family and work life.

The National Policy (1998) adopts the primary health concept, which includes the establishment of maternal health services to provide efficient and effective maternal health services to every women, mother-to-be and mothers. The National Population Policy (1998) aims to strengthen maternal and child care services. As a result of the 1994 Cairo International Conference on Population and Development (ICDP) in 1994 many governments of the world (including Nigeria) adopted the improvement of women's sexual and reproductive health as a key objective of the activities of governments.

In 1999, the Cross River State health sector like their counterparts in the other states and the Federal Capital Territory (FCT) had doctors, dentists, pharmacists, nurses, laboratory workers, community health workers, administrators, etc. who were demoralized, frustrated and underperforming.According to Joseph (2015), prior to May 1999, the Cross River State health sector lacked strategic

planning and systematic co-ordination. It lacked effective and efficient implementation of programmes, which resulted in duplication and massive waste of scare resources. There was also corruption and fraudulent practices or none issuance of receipts as well as removal of hospital equipment by individual health workers, etc.

Against this background, this study examines factors affecting maternal health using BokiLGA in Cross River State as a focal point.

Research Questions

1. Has primary healthcare centers (PHC) been a major means of achieving zero child death and maternal care?
2. What are the factors militating against the administration of child maternity and healthcare delivery in BokiLGA?
3. What is the attitude of rural women toward antenatal care?

II. LITERATURE REVIEW/ EMPIRICAL STUDIES

Globally, the estimated number of deaths worldwide in 2005 was 536,000 as against 529,000 in 2000. According to the WHO Factsheet (2008), 1500 women die from pregnancy or pregnancy-related complications every day. Most of these deaths occur in developing countries, and most are avoidable. Of all the health statistics compiled by the World Health Organization, the largest discrepancy between developed and developing countries occurred in maternal mortality. Ujah et al. (2005) note that 25% of females of reproductive age who lived in developedcountries contributed only 1% to maternal deaths worldwide. A total of 99% of all maternal deaths occur in developing countries. More than half of these deaths occur in sub-Saharan Africa and one-third in South Asia. The maternal mortality ratio in developing countries is 450 maternal deaths per 100,000 live births versus nine in developed countries. Fifteen countries have maternal mortality ratios of at least 1000 per 100,000 live births, of which all but Afghanistan and India are in sub-Saharan Africa: Afghanistan, Angola, Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Guinea-Bissau, India, Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone and Somalia (WHO, 2008). Nigeria has one of the highest maternal mortality rates in the world second to India, whose population is eight times larger than that of Nigeria (Mojekwu and Ibekwu, 2012). They have been visible progress in maternal mortality ratio (MMR) reduction at the global level, although with an exemption to developing countries. Agreeing to this, Shah and Say (2007) noted that the trend in developing countries is much worse, as studies from various countries of sub-Saharan Africa indicated that maternal mortality has not only continued to be high, but is also increasing after the launch of the Safe Motherhood Initiative (SMI) in Kenya in 1987.

Nigeria at present has one of the highest rates of maternal mortality in the developing world. According to Society of Gynecology and Obstetrics of Nigeria (SGON, 2004) report listed Nigeria as one of six countries that account for 50% of global estimates of maternal deaths. There exist wide variations in rates of maternal mortality between the six geo-political zones of Nigeria: the North East Zone has the highest rate of 1,549/100,000 live births, while the South West Zone has the lowest rate of 165/100,000 live births. Indeed, the country has been ranked as the second country after India with the highest absolute number of maternal deaths in the world. Consequently, there is a growing concern that the country may not achieve the maternal mortality reduction aim of the Sustainable Development Goals (SDGs), if the current trend continues. Okonofua (2010).Observed that, this consternation has created an emergency need for programmes and policies aimed at accelerating progress towards addressing the problem.Maternal mortality is one of the key indices of the state of health and quality of healthcare in any society. The death of a woman has devastating effect on the whole family and society at large. Maternal mortality remains unacceptably high, new data showed signs of progress in improving maternal health ─ the health of women during pregnancy and childbirth ─ with some countries achieving significant declines in maternal mortality ratios. But progress is still well short of the 5.5% annual decline needed to meet the SDGs target of reducing by three-quarters the maternal ratio by 2030. Progress has been made in sub-Saharan Africa; with some countries having maternal mortality levels between 1990 and 2008, though maternal mortality reductions has long been a challenge in low-income countries despite the data on levels of maternal mortality. Other regions, including Asia and Northern Africa, have made even greater headway (UNS, 2010). Hemorrhage, sepsis, unsafe abortion, obstructed labour, and hypertensive diseases of pregnancy have caused more than 80% of maternal deaths. Most of these deaths are preventable when there is access to adequate reproductive health services, equipment, supplies and skilled healthcare workers. More women are receiving antenatal care and skilled assistance during delivery.

In all regions, progress is being made in providing pregnant women with antenatal care. In North Africa, the percentage of women seeing a skilled health worker at least once during pregnancy increased by 70%. Southern Asia and Western Asia reported increases of almost 50%, with coverage increasing to 70% of pregnant women in Southern Asia and 79% in Western Asia. According to UNS (2010).In 2008, skilled health workers attended 63% of births in the developing world, increase from53% in 1990. Progress was made in all regions, but was especially dramatic in North Africa and South-eastern Asia, with increases of 74% and 63%, respectively although wide disparity still exists between providing pregnant women with antenatal care and skilled assistance during delivery. Poor women in rural andremote areas are least likely to receive adequate care. This is especially true for regions where the number of skilled health

workers remains low and maternal mortality high particularly sub-Saharan Africa, Southern Asia and Oceania. HIV is also curtailing progress, contributing significantly to maternal mortality in some countries. Nigeria has been mentioned by the United Nations as having one of the highest rates of maternal mortality in the world. Reducing high maternal mortality ratio is not just a technical and medical challenge but also largely a political one which requires the attention and commitment of political leaders.

According to WHO (2007) as cited by Mojekwu and Ibekwe (2012), maternal mortality, also known as maternal death, continues to be the major cause of death among women of reproductive age in many countries and remains a serious public health issues, especially in developing countries . Shah and Say (2006) define maternal death as death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Nigeria is the tenth most populous country in the world and the largest in sub-Saharan Africa, with an estimated population of 174,507,539. Toure, 1996;Kolawole, (2006) observed that, Nigeria's population growth rate has been driven by high fertility which has fallen in the last few decades but not as rapidly as the fall of the crude death rate. The Total Fertility Rate (TFR) declined modestly from 6.3 children per woman in 1981-1982to 5.7 children per woman in 2008. Understanding fertility desires and behavior requires a careful examination of women's and men's attitudes and behaviors about reproduction within their economic, social, and cultural context (Akinfeleye et al., 1994; Smith, 2004).

Supporting this assertion in the word of Daniel (2009), high population growth is related to the socio-economic development of any nation the effects of rapid population growth include reduced per capita income; high rural-urban migration; heavy pressure on social services, such as health care and education; high unemployment rates; poverty; land fragmentation and degradation; and communal clashes over arable land. Within families, elevated risks of maternal and child mortality and a higher risk of being trapped in poverty are areas of concernsas family increases. According to Adiri et al. (2010)high fertility is one of the primary determinants of rapid population growth, which can hinder socio-economic development. Thus, efforts to reduce poverty and promote sustainable development have included an emphasis on strengthening family planning programmes. The Nigerian health system as a whole has been plagued by problems of service quality, including unfriendly staff attitudes to patients, inadequate skills, decaying infrastructures and chronic shortages of essential drugs. Electricity and water supply are irregular and the health sector as a whole is in a dismal state.

In 2000, the World Health Organization ranked the performance of Nigeria's healthcare system 187th among 191 United Nations member states. Harrison (2009), a 2003 study revealed that only 4.2% of public facilities met internationally accepted standards for essential obstetric care. Approximately, two-thirds of all Nigerian women deliver outside of health facilities and without medically skilled attendants present. The state of well-being performance of the health system must be understood in the context of the country's long-standing problems with governance. Corruption in the political system is endemic, while social development, including the promotion of the health of Nigerian citizens, has been more a rhetorical than a real aim of the state.

Also, Nigeria has one of the worst records of maternal deaths in the world and this situation is worsening with time. The problem of poor organization and access to maternal health services has always been a major challenge in Nigeria ,maternal care in Nigeria is organized around three tiers: primary, secondary, and tertiary health care levels. Primary health centre are located in all the 774 local government councils in the country. Pregnant women are to receive antenatal care, delivery and postnatal care in the primary health centre nearest to them. In case of complications, they are referred to secondary care centre, managed by states, or tertiary centre, managed by the Federal Government. According to the 2008 Nigeria Demographic Health Survey (NDHS),Nigeria's maternal mortality ratio over the past five years ranged from 475 to 615 per 100,000 live births, with an average of 545/100,000 live births (NDHS, 2008). The United Nations, in 2010, reported that, although substantial progress has been made globally towards meeting to maternal and child healthcare.

Child health has lagged behind (Countdown, 2010). Data from the United Nations and the World Bank identified Nigeria as one of the worst countries for a woman to give birth, with women having one in thirteen chances of dying during pregnancy and child birth (United Nations MDGReport, 2008). It is estimated thatabout 59, 000 women die each year in Nigeria owing to pregnancy-related complications, which translates into144 maternal deaths on a daily basis. In 2003, the average maternal mortality ratio for Nigeria was put at704/100,000 live births, with a range of 165/100,000 live births in the southwest to 1,549/100,000 live births in the northeast of the country (NDHS, 2003).

According to Avidine (2010), sub-Saharan Africa is the region with the lowest levels of contraceptive use and the high levels of fertility rates. A study of six ethnic groups in Nigeria (Yoruba, Hausa, Fulani, Ibo, Kanuri, Efik, and Ibibio) found that all placed a high premium on large family size (.Socio-cultural factors also play a key role in influencing men and women's knowledge and practices related to maternal health. For instance, people in the northern part of Nigeria, are mostly Fulani/Hausa Muslims. Since men hold the primary decision-making power in the society, the decision to go to a health facility in an emergency must wait until the husband (or in-laws) give consent (Wyss et al., 1996). In addition, the low value placed on girl's education leads to low rates of girl's primary school enrolment. Even though knowledge about maternal health is not taught in school, the very fact of having

attended school seems to increase overall awareness and ability to obtain new knowledge, as has been seen in Nepal, Venezuela and south-western Nigeria(Kane, 2004; Hyacinth et al. 2006).Place of delivery is another important factor. The 2008 Nigerian Demographic and Health Survey (NDHS) reported that 90.2% of deliveries in the northeast region took place without a skilled birth attendant (SBA). The report also reveals that north-western Nigeria women who gave birth without a skilled attendant were perfectly divided. For example, 44% were assisted by relative or a traditional birth attendant and the other44% delivered completely alone (NDHS, 2008). Although delivering alone is quite rare in other countries, it is a routine among women in Hausa-Fulani society because it is considered shameful to be heard crying out during child birth (Yusuf, 2005). Rates of home deliveries exceed 90% in rural areas. Adamu et al. (2002), in a study based in rural Kano, found that 96.3% of women delivered or planned to deliver at home.

III. THEORETICAL FRAMEWORK

Functionalist Approach to the Health Care System of Nigeria

Functionalists generally adhere to the view that society can be understood in its totality as an entity unto itself. Among the earlier functionalist thinkers, it was not common to view society as an organism with differentiated parts that function together in order for it to adapt and survive in its environment. Although contemporary functionalists are not as crude, they tend to look at society as an integrated system of functionally interrelated structures; at times suggesting those societies have a life of their own and that their survival demands that particular needs of the system have to be met.

The contributions of Talcott Parsons to the theory of functionalism are the record of a life time of writing in the area of social theory (Farganis, 2003). Parsons attempted, in his several works, to develop concepts that would help organize our perceptions of social reality. In recasting the functional imperatives of a social system, Parsons developed a fourfold classification scheme with the acronym AGIL (Adaptation, Goal attainment, Integration and Latency*)*. Adaptation refers to the fact that systems are embedded in physical and socio-political environments to which they must adapt if they are to survive. Goal attainment refers to the need to define the primary goals of any system and the methods by which individuals accept those goals as their own and strive to achieve them. Integration refers to the need to coordinate the component parts of the system so that they contribute to the maintenance of the whole. Latency refers to those structures that serve to maintain and revitalize the motivation of individuals to perform their roles according to social expectations (Farganis, 2003).

Parsons further elaborated his conceptual scheme to a four-fold system. Each of the action systems, namely social, cultural, personality and the behavioural organism, is tied to the functional imperatives of a total system. Thus, the complex of institutions that we group under the rubric of socialization and social controlPerform the integrative functions of the system, whereas the values and norms that serve to motivate social action are grouped as part of the cultural system (Farganis, 2003). The personality system functions to attain the goals of the system and the behavioral organism which provides the energy for adaptation and transformation of the system in relation to its environment. In Nigeria, the most pressing emergency in the health sector is the health of mothers, during pregnancy and after birth. How can the system work in a different and better way to deliver better health outcomes when government spend about 70-80% of the country resources available for healthcare at the point of need of them. It can make a huge difference, especially in the issue of maternal mortality rate, if such funds that are available are spent for health care delivery (NAS, 2009). Primary health care is the key indicators of maternal health issues. The epidemiology of disease for women in Nigeria is haemorrhage, or complications of childbirth, like postpartum infections. Science is not needed in to handle these but the system of the health care delivery for women, should be organized to do things better in a more effective and efficient way. There should be replication of primary health care in Nigeria, most especially in the rural areas of Nigeria where pregnant mothers can have free health care services. The investment government has made in the health system in Nigeria over the years is so little compared to what obtains in developed countries. Communities having well-organized health insurance schemes can raise significant resources to deliver health care to women.

IV. RESEARCH MATERIALS AND METHOD

The researcher utilized secondary and primary data in the course of this research. Data was retrieved from existing records mostly from the publications of government, journal publications, internet, Newspaper and questionnaire was also administered among the population of study in Cross River State.The data collected from this study were presented, analyzed and interpreted with frequency distribution table and percentages and purposive sampling method is used to select respondent who are believed to have adequate knowledge of the subject matter

V. DATA PRESENTATION AND DISCUSSION OF FINDINGS

The research population for the study is health workers and beneficiaries of this maternity and child healthcare delivery from five (5) wards out of the eleven wards in Boki local Government Area, Since the entire LGA was not feasible to cover, the researcher purposive selected fifty (50) Health workers and one hundred beneficiaries of the scheme to make the sample size 150.

Table 1.1.1 Age Distribution of the Respondent

Age	Number of Respondents	Percentage (%)
20-30	32	21.3
31-40	29	19.3
41-50	28	18.7
50 -60	31	20.7
60+	30	20
Total	**150**	**100**

Source: field survey 2016

Table 1.1.1 shows that, the larger number of respondents were those aged 20-30, representing 21.3%, while the lower were age 41-50, representing 18.7%. This implies that 20-30 are the majority of the participant in this work.

Table 1.1.2 Sex Distribution of Respondents

Sex	Number of respondents	Percentage
Male	52	34.7
Female	98	65.3
Total	**150**	**100**

Source: field survey 2016.

Table 1.1.2 shows that 98 respondents representing 65.3% were female while 52 respondents representing 34.7% were male. This implies more female who happen to be the beneficiaries of these services were visible in this study.

Table 1.1.3 Distribution of respondents by education status

Educational qualification	Number of Respondents	Percentage
Primary School	21	14
Secondary school	30	20
Post- secondary school	49	32.7
Tertiary	50	33.3
Total	**150**	**100**

Source: field survey, 2016

From table 1.1.3 it shows that the highest number of respondents 50 representing 33.3% was pupils with tertiary education qualification and the lower were primary.

Table 1.1.4 Distribution of respondent by marital status

Marital status	Number of respondents	Percentage
Single	40	26.7
Married	60	40
Separated	50	33.3
Total	**150**	**100**

Source: field survey, 2016

From the table above, it shows that the highest respondent were the married women representing 40% of the respondents and the lower were the single representing 26.7%.

Table 5.1.6 has primary healthcare centers (PHC) been a major means of achieving zero child death and maternal care?

Status	Frequency	Percentage
YES	115	76.7
NO	35	23.3
TOTAL	**150**	**100**

Survey field, 2016

From the table above, it shows that 115 of the respondents representing 76.7% said ''YES'' that primary healthcare centers (PHC) been a major means of achieving zero child death and maternal care, since the PHC is closer to the people while 35 respondents representing 23.3% said ''NO'

Table 5.1.7 there is a resultant effect of drug misuse on the sustainable health of infants?

Status	Frequency	Percentage
YES	101	67.3
NO	49	32.7
TOTAL	**150**	**100**

Source: field survey by 2016

From the table above, it shows that 101 of the respondents representing 67.3% said ''YES'' that resultant effect on the sustainable health of infant as result of drug misusewhile 49 respondents representing 32.7% said ''NO''

Table 5.1.8 the quality of health care system determines the kinds of services render?

Status	Frequency	Percentage
YES	90	60
NO	60	40
Total	**150**	**100**

Source: field survey by 2016

From the table above, it shows that 90 of the respondents representing 60% said ''YES'' that the quality of healthcare system determine the kind of services render to the rural women while 60 respondents representing 40% said ''NO''

Table 5.1.9 lack of information among the rural women militates against the administration of child maternity and healthcare delivery?

Status	Frequency	Percentage
YES	120	80
NO	30	20
Total	**150**	**100**

Source: field survey by (2016)

Table 4.7 it shows that 120 of the respondents representing 80% agree that lack of information militate against the smooth implementation of healthcare service delivery while 30 respondents representing 20% said "NO"

Table 5.1.10 public lecture /campaign are one of the ways of curbing child morbidly rate?

Status	Frequency	Percentage
YES	110	73.3
NO	40	26.7
Total	**150**	**100**

Source: field survey by (2016)

Table 4.8 shows that 110 respondents representing 73.3 percent agree that public lecture /campaign are one of the ways of curbing drug child morbidity in the society by educating the rural women on the benefit of seeking healthcare services while 40 respondents representing 26.7 percent say NO.

Table 5.1.11 traditional birth attendant militate against healthcare delivery**?**

Status	Frequency	Frequency
YES	120	80
NO	30	20
Total	**150**	**100**

Source: field survey by (2016)

Table 4.3 is based on item (3) it shows that 120 of the respondents representing 80 percent said YES, that one of the factors militating against the smooth implementation of healthcare delivery is traditional birth attendant as most of the rural women prefer to give birth in native doctors place or in the church . While 30 respondents representing 20 percent say NO. As a way of curbing this, Cross River State Government through the office of the Director General, Cross River State Primary Healthcare Delivery Agency integrated Traditional Birth Attendants (TBAs) into its healthcare system, considering their role in the society, in terms of taking delivery of babies, especially in rural areas. As a follow up mechanism, the government trained TBAs on their new roles of referring patients from their various communities to health facility in their respective community

VI. CONCLUSION

The main factors affecting maternal mortality ratio, as determined by this study, is subdivided into direct maternal death and indirect maternal death. Direct maternal deaths are complications of the pregnancy itself; thatis, complications of pregnancy, labour, delivery and complications that may arise within six weeks after the delivery period (postpartum). Direct cause accounts for about 80% of all maternal deaths and cannot be predicted.

These direct causes include haemorrhage (uncontrolled bleeding), sepsis (infections), hypertensive disorders (complications of high blood pressures), prolonged or obstructed labour, and unsafe abortion. Direct maternal deaths are those related to medical illness before the outset of pregnancy. These medical conditions are usually aggravated by the body changes associated with pregnancy or because of the demand of the pregnancy. These include malaria, anaemia (shortage of blood), HIV/AIDS, heart diseases, and hepatitis. Among the direct causes, haemorrhage accounts for about 25%, of all deaths in developing countries. Other factors such as reproductive factors, obstetric complications, health service factors and socio-cultural factors, are associated with high maternal mortality. Other underlying factors related to maternal deaths include maternal age, socio-economic factors, cultural practices, teenage pregnancy, heavy domestic duties during pregnancy and after childbirth,religion, attitudinal issues of health workers and environmental infrastructures. Most maternal deaths are avoidable. If a woman has access to antenatal care during pregnancy, has trained (skilled care) at labour, and both the baby and the mother are under standard medical care during and after delivery, and continue till the first two weeks after delivery, excess bleeding will be identified at the right time. Also, underlying causes of any abnormal bleeding will be indentified and necessary intervention will be provided, with blood transfusion, if necessary

VII. RECOMMENDATION

1. There is need to reduce adolescent pregnancy which is strongly linked to gender equality
2. Provision of better data for all women and girls, and achieve universal coverage of skilled birth attendants
3. There is need for increase access to clean water and sanitation and reducing malaria, tuberculosis, polio and the spread of HIV/AIDS from mother to child.

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